depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit, the director shall determine an interim rate that approximates the property rental rate. The property rental rate shall be determined as follows:

(1) Except as determined pursuant to this section and as modified by section 56-109, Idaho Code:

Property rental rate = ("Property base") x ("Change in building costs") x (40 − "Age of facility") / 40

where:

(a) "Property base" = $9.24 for all facilities.

(b) "Change in building costs" = 1.0 from April 1, 1985, through December 31, 1985. Thereafter "Change in building costs" will be adjusted for each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year, published by the Marshall Swift Valuation Service. However, for free-standing skilled care facilities "change in building costs" = 1.145 from July 1, 1991, through December 31, 1991. Thereafter, change in building costs for free-standing skilled care facilities will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs available in September of the prior year, whichever is greater.

(c) "Age of facility" = the director shall determine the effective age, in years, of the facility by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof shall be assigned an age of more than thirty (30) years. However, beginning July 1, 1991, for free-standing skilled care facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under subsection (1) of this section. This revised age shall not increase over time.

(i) If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the director shall set the effective age at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. The director shall compute an appropriate age for facilities when documentation is provided to reflect expenditures for building expansion or remodeling prior to the effective date of this section. The computation shall decrease the age of a facility by an amount consistent with the expenditure and the square footage impacted and shall be calculated as follows:

1. Determine, according to indexes published by the Marshall Swift Valuation Service, the construction cost per square foot of an aver-

age class D convalescent hospital in the western region for the year in which the expansion or renovation was completed.

2. Multiply the total square footage of the building following the expansion or renovation by the cost per square foot to establish the estimated replacement cost of the building at that time.

3. The age of the building at the time of construction shall be multiplied by the quotient of total actual renovation or remodeling costs divided by replacement cost. If this number is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number. In no case will the age be less than zero.

(ii) The director shall adjust the effective age of a facility when major repairs, replacement, remodeling or renovation initiated after April 1, 1985, would result in a change in age of at least one (1) year. Such changes shall not increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the adjusted property base determined in subsections (1)(a) and (1)(b) of this section and the rental rate paid to the facility at the time of completion of such changes but before the change component has been added to said rate. The adjusted effective age of the facility will be used in future age determinations, unless modified by provisions of this chapter.

(iii) The director shall allow for future adjustments to the effective age of a facility or its rate to reimburse an appropriate amount for property expenditures resulting from new requirements imposed by state or federal agencies. The director shall, within twelve (12) months of verification of expenditure, reimburse the medicaid share of the entire cost of such new requirements as a one-time payment if the incurred cost for a facility is less than one hundred dollars ($100) per bed.

(d) At no time shall the property rental rate, established under subsection (1) of this section, be less than that allowed in subsection (1)(c)(ii), with the rate in effect December 31, 1988 being the base. However, subsequent to the application of this paragraph, before any rate increase may be paid, it must first be offset by any rate decrease that would have been realized if the provisions of this paragraph had not been in effect.

(2) A "grandfathered rate" for existing facilities will be determined by dividing the audited allowable annual property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985 by the total patient days in the period July 1, 1984 through June 30, 1985. The property rental rate will be the greater of the amount determined pursuant to subsection (1) of this section, or the grandfathered rate. The director shall adjust the grandfathered rate of a facility to compensate the owner for the cost of major repairs, replacement, expansion, remodeling and renovation initiated prior to April 1, 1985, and completed after January 1, 1985, but completed no later than December 31, 1985. (The director shall adjust the grandfathered rate of a facility to compensate the owner for the cost of major repairs, replacement, expansion, remodeling and renovation initiated prior to April 1, 1985, and completed after January 1, 1985, but completed no later than December 31, 1985.) For facilities receiving a grandfa-

thered rate making major repairs, replacement, expansion, remodeling or renovation, initiated after January 1, 1986, the director shall compare the grandfathered rate of the facility to the actual depreciation, amortization, and interest for the current audit period plus the per diem of the recognized cost of major repairs, replacement, expansion, remodeling or renovation, amortized over the American hospital association guideline component useful life. The greater of the two (2) numbers will be allowed as the grandfathered rate. Such changes shall not increase the allowable grandfathered rate by more than three-fourths (3/4) of the difference between the current grandfathered rate and the adjusted property base determined in subsections (1)(a) and (1)(b) of this section.

(3) The property rental rate per day of care paid to facilities with leases signed prior to March 30, 1981, will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983 through July 1, 1984. Effective July 1, 1989, the director shall adjust the property rental rate of a leased skilled facility under this paragraph to compensate for the cost of major repairs, replacement, expansion, remodeling and renovation initiated after January 1, 1985, by adding the per diem of the recognized cost of such expenditures amortized over the American hospital association guideline component useful life. Such addition shall not increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the current property rental rate and the adjusted property base as determined in paragraphs (a) and (b) of subsection (1) of this section. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement shall be at a rate per day of care which reflects the increase in the lease rate. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement shall be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters costs. After the effective date of this subsection, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by purchase of the facility, the property rental rate shall become the amount determined by the formula in subsection (1) of this section as of the date on which the lease is or could be terminated.

(4)(a) In the event of a sale, the buyer shall receive the property rental rate as provided in subsection (1) of this section, except under the conditions of paragraph (b) of this subsection or except in the event of the first sale for a free-standing skilled care facility receiving a grandfathered rate after June 30, 1991, whereupon the new owner shall receive the same rate that the seller would have received at any given point in time.

(b) In the event of a forced sale of a facility where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, not modified by section 56-109, Idaho Code, whichever is higher, but not exceeding the

rate that would be due the seller. [I.C., § 56-108, as added by 1985, ch. 128, § 3, p. 312; am. 1986, ch. 87, § 3, p. 250; am. 1989, ch. 417, § 1, p. 1018; am. 1990, ch. 67, § 1, p. 146; am. 1991, ch. 160, § 1, p. 384; am. 1993, ch. 351, § 1, p. 1306.]

Compiler's notes. The fourth sentence of subsection (2) of this section was placed in parentheses by the compiler as surplusage.

Sections 2 and 4 of S.L. 1986, ch. 87 are compiled as §§ 56-104 and 56-113, respectively.

Section 2 of S.L. 1990, ch. 67, declared an emergency. Approved March 20, 1990, effective retroactively to July 1, 1989.

Section 2 of S.L. 1993, ch. 351 is compiled as § 56-113.

Sec. to sec. ref. This section is referred to in § 56-113.

56-109. Property rental rate implementation schedule. — The property rental rate as defined in section 56-108, Idaho Code, shall be phased in through December 31, 1989. Facilities with existing rates equal to or greater than the property rental rate according to provisions of section 56-108, Idaho Code, shall not be phased in. The phase-in shall be implemented so that when the grandfathered rate as defined in section 56-108, Idaho Code, is below the property rental rate, the rate paid will be determined as follows:

(1) For the period ending December 31, 1985: grandfathered rate plus twenty percent (20%) of the difference between grandfathered rate and property rental rate.

(2) For the period January 1, 1986 through December 31, 1986: grandfathered rate plus forty percent (40%) of the difference between grandfathered rate and property rental rate.

(3) For the period January 1, 1987 through December 31, 1987: grandfathered rate plus sixty percent (60%) of the difference between grandfathered rate and property rental rate.

(4) For the period January 1, 1988 through December 31, 1988: grandfathered rate plus eighty percent (80%) of the difference between grandfathered rate and property rental rate.

(5) For the period January 1, 1989 forward: property rental rate. [I.C., § 56-109, as added by 1985, ch. 128, § 4, p. 312.]

PART B.

FREE-STANDING SKILLED CARE AND INTERMEDIATE CARE FACILITIES

56-110. Existing free-standing skilled care facilities. — (a) Not later than January 1, 1982, and prior to the beginning of each fiscal year thereafter, the director shall determine the maximum base rate for all free-standing skilled care facilities that were under medicaid contract with the director on or before January 1, 1982, as a class, using the following method:

(1) First, from the most recent cost report submitted by each free-standing skilled care facility, the director shall prior to ninety (90) days before the beginning of the period for which the percentile cap is being determined, add together all nonproperty, nonutility costs (administration,

food, nursing services, and operations) incurred by each facility; provided, that, where such facility provides care to the mentally-retarded, costs peculiar to such care shall first be exempted from consideration herein and shall be paid in accordance with the provider reimbursement manual, as defined in this subsection. A cost report covering less than a twelve (12) month period shall be annualized for purposes of determining current interim rate entitlement and percentile cap cost data as further provided;

(2) Next, the director shall divide the sum obtained from paragraph (1) of this section by the total number of patient-days of care, taken from each cost report;

(3) Next, the director shall multiply the cost of care per patient-day obtained from paragraph (2) of this section by the percentage representing the annual combined inflator index, for the period in which the base rate is to be effective, as determined and agreed upon pursuant to section 56-130, Idaho Code;

(4) Next, the director shall combine the results from each such facility obtained from paragraph (3) to establish the range of costs of care per patient-day for all such facilities; and

(5) Next, the director shall calculate the mean cost of care per patient-day and the standard deviation from such mean, which shall be used to determine the base rate as specified in section 56-103(a), Idaho Code.

(6) Any cost increases resulting from federal or state law or rule changes shall be passed through automatically and will be treated as costs separate from the cap cost center until such time as these costs have become part of the data base for calculating the percentile cap. The providers efficiency incentive shall not be affected by these increases.

The result obtained from paragraph (5) or (6) of this subsection shall constitute the basic payment for the cost of care per patient-day in each free-standing skilled facility in the class, and the director shall notify each such facility of such payment not later than sixty (60) days prior to the fiscal year in which it is to become effective. A rebuttable presumption exists with respect to costs above the basic payment that a facility incurring such costs is not economically and efficiently operated, taking into account economic conditions and trends during the period covered by such costs, and that such costs are not reasonable. Such rebuttable presumption shall not be employed to justify costs below the basic payment. For purposes of this subsection, "audited cost report" means a cost report prepared and submitted to the director by a free-standing skilled care facility and audited by the director in accordance with the provider reimbursement manual, as promulgated by the director for the Idaho medicaid program, and the health insurance manual 15, as promulgated by the United States department of health and human services or its predecessor agency; provided, that the provider reimbursement manual shall take precedence over the health insurance manual 15 in case of conflict, ambiguity or disagreement.

(b) In addition to the basic payment per patient-day of care, as calculated in subsection (a) of this section, each free-standing skilled nursing facility shall be paid as a part of the monthly prospective payment:

(1) Its property rental rate plus projected property taxes, reasonable property insurance, and utility costs, to be determined by dividing its total projected property taxes, reasonable property insurance, and utility costs for its upcoming fiscal year, by the projected number of patient-days; and

(2) A monthly incentive payment equal to the computed difference between the facility's actual payment per patient-day and the base rate established for the class pursuant to section 56-103(a), Idaho Code, and this part. This computed difference shall be:

1. One-half (1/2) of the difference, where the one hundredth percentile applies to such facility's class;
2. One-third (1/3) of the difference, where the ninetieth percentile applies to such facility's class;
3. One-fourth (1/4) of the difference, where the eightieth percentile applies to such facility's class; or
4. One-sixth (1/6) of the difference, where the seventy-fifth percentile applies to such facility's class;

provided, that in no event shall the computed difference exceed one dollar and fifty cents ($1.50) per patient-day.

(c) Actual payments made by the director to each free-standing skilled care facility pursuant to sections 56-103 and 56-105, Idaho Code, and this section, shall be subject to audit and settlement under section 56-107, Idaho Code. In no event shall reimbursement to any facility exceed the usual and customary charges made to private pay patients. [I.C., § 56-110, as added by 1981, ch. 159, § 1, p. 271; am. 1984, ch. 118, § 2, p. 264; am. 1985, ch. 128, § 5, p. 312; am. 1989, ch. 425, § 1, p. 1052.]

Compiler's notes. The words enclosed in parentheses so appeared in the law as enacted.

Section 1 of S.L. 1984, ch. 118 is compiled as § 56-101.

Sec. to sec. ref. This section is referred to in §§ 56-112, 56-113 and 56-114.

ANALYSIS

Costs beyond facility control.
—Burden of proof.
—Findings by hearing officer.
Inefficient operation.

Costs Beyond Facility Control.

Regulation, which provided that costs incurred by long-term health care facility in excess of the percentile cap will be disallowed unless the facility can establish that such costs were beyond its control, on its face was valid and reasonably encouraged efficiency while adequately reimbursing facilities. Idaho County Nursing Home v. Idaho Dep't of Health & Welfare, 120 Idaho 933, 821 P.2d 988 (1991).

Where the District Court on appeal from the agency proceedings determined that the evidence did not support the finding that the costs expended by long-term healthcare facility for its employee retirement benefits (PERSI) could reasonably be controlled and the District Court noted that it would cost Idaho Nursing almost $500,000 to withdraw from the PERSI program, the finding of the Department and the hearing officer that the costs were within the facilities control were erroneous and were reversed. Idaho County Nursing Home v. Idaho Dep't of Health & Welfare, 120 Idaho 933, 821 P.2d 988 (1991).

—Burden of Proof.

The Department of Health and Welfare may not simply rely on the fact that a facility exceeded the percentile cap to prove inefficiency; once the presumption of this section is rebutted there no longer remains an assumption that the provider's facility is inefficiently

operated and the Department has the same evidentiary burden as the facility; therefore, in that circumstance the Department must then prove that the facility is inefficiently operated in order to deny payments for those costs that exceed the percentile cap. Idaho County Nursing Home v. Idaho Dep't of Health & Welfare, 120 Idaho 933, 821 P.2d 988 (1991).

The burden is on the long-term healthcare facility to demonstrate its right to reimbursement; however, once the facility has submitted substantial evidence that it is efficiently operated and has incurred costs beyond its control, the presumption contained in subdivision (a)(6) of this section disappears, and the facility has made a prima facie case that the costs are reasonable. Idaho County Nursing Home v. Idaho Dep't of Health & Welfare, 120 Idaho 933, 821 P.2d 988 (1991).

—Findings by Hearing Officer.

Once a facility has rebutted the presumption of this section by presenting evidence that the costs in excess of the percentile cap are beyond its control, the hearing officer must make a finding based on the evidence without reliance on the presumption. Idaho County Nursing Home v. Idaho Dep't of Health & Welfare, 120 Idaho 933, 821 P.2d 988 (1991).

Inefficient Operation.

Where the Department of Health's findings of fact were inadequate to support its decision that nursing home exceeded Medicaid percentile caps due to inefficient operation, the matter was remanded to the Department of Health with instructions that the Department make specific findings of fact and conclusions of law with respect to the questions of whether nursing home was efficiently operated and to what extent its costs above the percentile cap were justified based solely upon the present evidentiary record, without the taking of any new or additional evidence. Idaho City Nursing Home v. Department of Health, 124 Idaho 116, 856 P.2d 1283 (1993).

56-111. New free-standing skilled care facilities. — For the first fiscal year of a free-standing skilled care facility established on or after January 1, 1982, which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment in the same manner as specified in section 56-110, Idaho Code, except that, in lieu of the most recent audited cost report, the free-standing skilled care facility shall submit to the director, not later than ninety (90) days prior to the beginning date of the fiscal year in which the prospective rate is to be effective, a prospective budget containing the information necessary to complete the formula set forth in section 56-110, Idaho Code. Thereafter, such determination for such facility shall be done in accordance with section 56-110, Idaho Code. [I.C., § 56-111, as added by 1981, ch. 159, § 1, p. 271; am. 1984, ch. 118, § 3, p. 264; am. 1985, ch. 128, § 6, p. 312.]

Sec. to sec. ref. This section is referred to in §§ 56-113 and 56-114.

56-112. Free-standing intermediate care facilities. — (a) Not later than January 1, 1982, and prior to the beginning of each fiscal year thereafter, the director shall determine the total prospective payment rate for all free-standing intermediate care facilities under medicaid contract with the director on or before the effective date of this chapter in the same manner as set forth in section 56-110, Idaho Code.

(b) For the first fiscal year of a free-standing intermediate care facility established on or after January 1, 1982, which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment for such facility in the same manner as specified in section 56-111, Idaho Code. Thereafter, such determination for such facility shall be done in accordance with subsection (a) of this section. [I.C., § 56-112, as added by

1981, ch. 159, § 1, p. 271; am. 1984, ch. 118, § 4, p. 264; am. 1985, ch. 128, § 7, p. 312.]

Sec. to sec. ref. This section is referred to in § 56-114.

56-113. Intermediate care facilities for the mentally retarded. — (a) Services provided by intermediate care facilities for the mentally retarded shall also be reimbursed in accordance with the provisions of this chapter, except that property costs shall not be reimbursed as provided in section 56-108, Idaho Code. Instead, property costs shall be reimbursed in accordance with applicable provisions of the health insurance manual 15, as promulgated by the U.S. department of health and human services (SSA HIM-15). Provided, that facilities in operation prior to April 1, 1993, may negotiate a grandfathered rate for property reimbursement with the director. In no event shall the reimbursement of property costs to this class of facility exceed, in the aggregate, the amount which would be reimbursed using medicare payment principles as defined in SSA HIM-15.

(b) Not later than January 1, 1982, and prior to the beginning of each fiscal year thereafter, the director shall determine the total prospective payment rate for all intermediate care facilities for the mentally retarded under medicaid contract with the director on or before the effective date of this chapter in the same manner as set forth in section 56-110, Idaho Code, except that the computation of the prospective payment according to the manner set forth in subsection (b)(1) of section 56-110, Idaho Code, shall include property costs as calculated in subsection (a) of this section.

(c) For the first fiscal year of an intermediate care facility for the mentally retarded established on or after January 1, 1982, which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment for such facility in the same manner as specified in section 56-111, Idaho Code. Thereafter, such determination for such facility shall be done in accordance with subsection (b) of this section. [I.C., § 56-113, as added by 1981, ch. 159, § 1, p. 271; am. 1984, ch. 118, § 5, p. 264; am. 1985, ch. 128, § 8, p. 312; am. 1986, ch. 87, § 4, p. 250; am. 1993, ch. 351, § 2, p. 1306.]

Compiler's notes. Section 6 of S.L. 1984, ch. 118 is compiled as § 56-120.

Section 9 of S.L. 1985, ch. 128 is compiled as § 56-120.

Section 3 of S.L. 1986, ch. 87 is compiled as § 56-108.

Section 1 of S.L. 1993, ch. 351 is compiled as § 56-108.

Section 5 of S.L. 1986, ch. 87 declared an emergency. Approved March 22, 1986.

Section 3 of S.L. 1993, ch. 351 declared an emergency. Approved April 1, 1993.

Sec. to sec. ref. This section is referred to in § 56-108.

56-114. New free-standing special care facilities. — For the first fiscal year of a free-standing special care facility established on or after January 1, 1989, which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment for such facility in the same manner as specified in section 56-111, Idaho Code.

Thereafter, such determination for such facility shall be done in substantially the manner required in sections 56-110, 56-112 and 56-113, Idaho Code. [I.C., § 56-114, as added by 1988, ch. 155, § 2, p. 279.]

Compiler's notes. Sections 1 and 3 of S.L. 1988, ch. 155 are compiled as §§ 56-101 and 56-131, respectively.

56-115. Capitalization of assets. — For purposes of reporting costs to the department of health and welfare, each skilled care facility shall not capitalize minor movable equipment but shall expense it. Major movable equipment shall be capitalized. As used herein, equipment used directly or indirectly in providing health care for which medicaid reimbursement may be provided and which costs five hundred dollars ($500) or less shall be minor movable equipment and may be expensed as of the date of purchase. Major movable equipment which costs more than five hundred dollars ($500), must be capitalized and depreciated over the estimated useful life of the equipment under the rules of generally accepted accounting principles. [I.C., § 56-115, as added by 1989, ch. 362, § 1, p. 907.]

56-116. [Reserved.]

56-117. Payment of special rates. — The director shall have authority to pay facilities at special rates for care given to patients who have long term care needs beyond the normal scope of facility services. Patients with such needs may include, but are not limited to, ventilator assisted patients, certain pediatric patients, certain comatose patients, and certain patients requiring nasogastric or intravenous feeding devices. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The cost to a facility for services provided pursuant to the provisions of this section will be excluded from the computation of payments or rates under other provisions of this chapter. [I.C., § 56-117, as added by 1989, ch. 362, § 2, p. 907.]

56-118. Reimbursement for oxygen concentrators. — Oxygen concentrators used in lieu of supplying long-term care patients with bottled oxygen may, at the facility's option, be treated as an expense item in the year of acquisition and the cost thereof may be reported in the same expense category as oxygen. [I.C., § 56-118, as added by 1989, ch. 362, § 3, p. 907.]

56-119. [Reserved.]

PART C.

HOSPITAL-BASED FACILITIES

56-120. Existing hospital-based facilities. — (a) Not later than January 1, 1982, and prior to the beginning of each fiscal year thereafter, the director shall determine the maximum base payment rate for all hospital-based facilities that were under medicaid contract on or before such effective date as a class, using the following method:

(1) First, using worksheet B of the most recent cost report, or the most recent audited medicare cost report, if available, submitted to the director by each hospital-based facility, the director shall subtract such facility's total direct costs (excluding property and utility costs) from the sum of total general, ancillary and routine service costs (excluding property and utility costs) of both the facility and the hospital;

(2) Next, again using worksheet B of the same medicare cost report submitted by such facility, the director shall determine a percentage by dividing the sum of the total indirect costs of the hospital and the facility into the total indirect costs of the facility;

(3) Next, the director shall multiply the total direct general service costs (excluding property and utility costs), as used in paragraph (1) of this subsection, by the percentage derived from paragraph (2) of this subsection;

(4) Next, the director shall add to the total direct costs of the facility, as used in paragraph (1) of this subsection, the sum derived from paragraph (3) of this subsection and total costs attributable to central service, oxygen, and physical therapy services, taken from worksheet C of the facility's medicare cost report;

(5) Next, the director shall divide the sum derived from paragraph (4) of this subsection by the facility's total number of patient-days in the fiscal year covered by that facility's medicare cost report;

(6) Next, the director shall multiply the cost of care per patient-day obtained from paragraph (5) of this subsection by the percentage representing the annual combined inflator index for the period in which the base rate is to be effective, as determined and agreed upon pursuant to section 56-130, Idaho Code;

(7) Next, the director shall combine the results from each hospital-based facility, as obtained from paragraph (6) of this subsection, to establish the range of costs of care per patient-day for all such facilities in the class; and

(8) Next, the director shall calculate the mean cost of care per patient-day for the class and the standard deviation from such mean, which shall be used to determine the base rate for the class, as specified in section 56-103(a), Idaho Code.

The cost per patient-day resulting from paragraph (8) of this subsection shall constitute the basic payment for the cost of care per patient-day in each hospital-based facility in the class, and the director shall notify each such facility of such rate not later than sixty (60) days prior to the beginning date of the fiscal year in which it is to be effective. For purposes of this